U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 July 2007

In the Matter of:

W.C.,
Claimant

Case No.: 2004-BLA-6602

v.

ABERRY COAL, INC.,
Employer

and

SECURITY INSURANCE COMPANY
OF HARTFORD,
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Leroy Lewis, Esq.
Hyden, Kentucky
For the Claimant

H. Ashby Dickerson, Esq.
Penn Stuart
Abingdon, Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death

was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on April 5, 2006, in Hazard, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director, OWCP, was not represented at the hearing. The Claimant was the only witness. Transcript ("Tr.") 9-21. Director's Exhibits ("DX") 1-38 and Employer's Exhibits ("EX") 1-20 were admitted into evidence without objection. Tr. 6, 7. The Claimant did not offer any additional exhibits. The record was held open after the hearing to allow the parties to submit closing arguments. The Claimant and the Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence unless otherwise noted, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on November 16, 1992. DX 1. The claim was denied by Administrative Law Judge J. Michael O'Neill on August 29, 1995, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled.

The Claimant filed his current claim on June 4, 2003. DX 3. The Director issued a proposed Decision and Order awarding benefits on April 13, 2004. DX 28. The Employer appealed on May 18, 2004. DX 31. The claim was referred to the Office of Administrative Law Judges for hearing on July 30, 2004. DX 36.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on June 4, 2003. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). Pursuant to 20 CFR § 725.309(d) (2006), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2006). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Employer are:

1. Whether the claim was timely filed.

2. How long the Claimant worked as a miner.

3. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

4. Whether his pneumoconiosis arose out of coal mine employment.

5. Whether he is totally disabled.

6. Whether his disability is due to pneumoconiosis.

7. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2006).

Tr. 5, DX 36. The Employer withdrew the issue of whether it is the Responsible Operator, and reserved its rights to challenge the statute and regulations. Tr. 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the 2006 hearing and at a previous hearing held on January 31, 1995, DX 1-22. He was 65 years old at the time of the 2006 hearing. He is a widower with no dependents. He has a fifth or sixth-grade education. Tr. 9, DX 1-32.

The Claimant alleged 31 years of coal mine employment. DX 3. The District Director found that he had 28 years of coal mine employment. DX 28. At the previous hearing, the Employer stipulated to at least 26 years of coal mine employment. DX 1-30. Based on work histories contained in the file, Social Security records, and testimony, I find that the Claimant had at least 28 years of coal mine employment. His jobs varied. He testified that he began working in the coal mine at the age of 16 pushing coal through a tipple. Tr. 11. During his years as a coal miner, he worked as a loader, a cutter, a coal truck driver, and a repairman. Tr. 10-12. According to the Claimant, he was exposed to coal dust and inhaled coal dust on a daily basis. Tr. 12. The Claimant would usually work 12 to 13 hours a day, six days per week. Tr. 12-13. He left the mines in 1992, when the mine closed down. DX 3, DX 1-40. His last coal mine employment was in Kentucky. Tr. 8. Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

When asked about his smoking history, the Claimant estimated that he had been smoking since the age of 15 at a rate of two packs per day. Tr. 20-21. He gave similar testimony at the previous hearing, saying he started at age 16-18, smoking two packs per day, having cut back to

half a pack by the time of the 1995 hearing. DX 1-20. I find that the Claimant had a 60-70 pack year smoking history.

He began having symptoms such as shortness of breath while working in the mines. DX 1-35. At the time of the 2006 hearing, he was experiencing continued, worsening problems with breathing. His breathing problems cause him to be unable to sleep at night. Tr. 13. The Claimant added that he did not have these breathing problems prior to working in the coal mines. Tr. 14. Dr. Stepp treats him for his breathing problems. Tr. 14-15. She prescribes inhalers, breath treatments, and other medications to target his breathing problems. Tr. 15-16. The Claimant testified that he coughs and wheezes all the time and can only walk about 100 feet before becoming too winded; he cannot walk up hill, and had to stop hunting. Tr. 16-18. He believes that his breathing problems prevent him from going back to work in the coal mines. Tr. 18.

Timeliness

Under § 932(f) of the Act, 30 U.S.C. § 932(f), implemented at 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Twenty CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. At the hearing, the Claimant was not asked whether or when a doctor has told him he is totally disabled due to pneumoconiosis. There is no evidence in the file that he was ever told that he was totally disabled by pneumoconiosis before he filed his current claim. None of the doctors who gave an opinion in the original claim believed him to be disabled. The Employer has offered no evidence or argument on this issue. I find that the presumption has not been rebutted, and the claim is timely.

Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The Claimant's previous claim was denied by Administrative Law Judge J. Michael O'Neill on August 29, 1995, and the denial became final one year later. As will be discussed in more detail below, pulmonary function tests and medical reports indicate that the Claimant now has a pulmonary impairment which is totally disabling. This constitutes a material change in conditions.[1] Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. Evidence admitted

[1] In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), a multiple claim arising under the pre-amendment regulations at 20 C.F.R. § 725.309 (2000), the Court reiterated that its previous decision in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), requires that the ALJ resolve two specific issues prior to finding a "material change" in a miner's condition: (1) whether the miner has presented evidence generated since the prior denial establishing an element of entitlement previously adjudicated against him; and, (2) whether the newly submitted evidence differs "qualitatively" from evidence previously submitted. Specifically, the *Flynn* Court held that "miners whose claims are governed by this Circuit's precedents must do more than satisfy the strict terms of the one-element test, but must also demonstrate that this change rests upon a qualitatively different evidentiary record." *See also, Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608-610 (6th Cir. 2001). Once a "material change" is found, then the ALJ must review the entire record *de novo* to determine ultimate entitlement to benefits. As the discussion below demonstrates, the record in the current claim is qualitatively different from the prior claim on the issue of whether the Claimant is totally disabled, as he has undergone a significant decline in pulmonary function.

in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2006). 20 CFR § 725.309(d)(1) (2006). Moreover, no findings in the prior claim are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2006).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings relied upon by the parties in connection with the current claim. X-ray interpretations submitted by the parties in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records and records from the prior claim are not subject to the limitations.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column. An x-ray reading which exceeds the limitations does not appear on the table. *See* note 3 below.

Physicians' qualifications appear after their names. Qualifications of physicians who read x-rays in connection with the black lung claim have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties. [2] If no qualifications are noted for any of the physicians on either table below, it means that either they have no special qualifications for reading x-rays, or I have been unable to

[2] NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, February 2, 2007, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_02_07.HTM . Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org. The parties were notified at the hearing that I proposed to take judicial notice of physician qualifications listed on the Internet by these organizations, and had no objection to my doing so. Tr. 8.

ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; B=NIOSH certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
06/21/03	**DX 9 Baker B ILO Classification 1/0**	**EX 3 Scott B/BCR**[3]	**DX 10 Barrett BCR/B Read for quality only Quality 1 (Good)**
12/08/03		**EX 2 Halbert B/BCR**	
09/21/04		**EX 1 Wheeler B/BCR**	
04/15/05			EX 13 Ayos COPD. Slightly increased interstitial markings.

X-ray interpretations from the prior claim appear on the following chart:

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
06/18/92	DX 1 Anderson ILO Classification 1/1	DX 1 Wiot BCR/B DX 1 Spitz BCR/B DX 1 Fino B	

[3] The Employer submitted a second re-reading of this x-ray by Dr. Scatarige as EX 19, to which the Claimant did not object. However, I have not considered it, because each party is entitled to submit only one re-reading of the Department of Labor sponsored x-ray. 20 CFR § 725.414(a)(2)(ii) and (3)(ii) (2006). The Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties, *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-169 (2004), and that a party who fails to argue "good cause" when it seeks admission of excess evidence, waives the argument, *Brasher v. Pleasant View Mining Co.*, 23 B.L.R. 1- ___, BRB No. 05-0570 BLA (Apr. 28, 2005).

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
06/29/92	DX 1 Myers A ILO Classification 1/1 DX 1 Aycoth B ILO Classification 1/2	DX 1 Wiot BCR/B DX 1 Spitz BCR/B DX 1 Pendergrass BCR/B DX 1 Fino B	
07/13/92		DX 1 Wiot BCR/B DX 1 Spitz BCR/B DX 1 McLoud BCR/B	DX 1 Gilbert No active cardiopulmonary pathology
10/12/92		DX 1 Vuskovich B ILO Classification 0/0 DX 1 Fino B DX 1 Spitz BCR/B DX 1 Wiot BCR/B	
12/15/92	DX 1 Wicker A ILO Classification 1/0	DX 1 Sargent BCR/B DX 1 Gogineni BCR/B DX 1 Abramowitz BCR/B DX 1 Binns BCR/B	
10/07/93		DX 1 Dahhan B DX 1 Fino B DX 1 Spitz BCR/B DX 1 Wiot BCR/B	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
03/08/94		DX 1 Wiot BCR/B DX 1 Spitz BCR/B DX 1 McLoud BCR/B	DX 1 Patel No active disease. DX 1 Gilbert Emphysematous changes with increased markings.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction or restriction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim.[4] Pulmonary function studies submitted by the parties in connection with the current claim were in accordance with the limitations contained in 20 CFR § 725.414 (2006). Treatment records and records from the prior claim are not subject to the limitations. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	Age Height[5]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 9 06/21/03 Baker	62 73.25"	1.58	4.56	35%		Yes	Moderate to severe obstructive defect. Valid per Dr. Burki, DX 9.

[4] The Employer submitted an analysis of a pulmonary function test administered on February 27, 2006, by Dr. Long, who said the results were invalid. EX 18. However, neither party offered the test results into the record.

[5] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 73.25" to 74", I have taken the mid-point (73.6") in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height[5]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
EX 2 Rosenberg 12/08/03	62 74”	0.90 1.38	3.31 3.44	27% 40%	26 44	Yes Yes	Severe obstruction, no restriction
EX 1 Dahhan 09/16/04	63 187 cm (73.6”)	0.96 1.05	2.48 2.71	39% 39%	23 31	Yes Yes	Severe partially reversible obstructive abnormality.

The following chart summarizes the results of the pulmonary function studies available in connection with the prior claim.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 06/18/92 Anderson	51 74”	3.40	4.92	69%	118.55	No	
DX 1 06/29/92 Myers	51 74”	2.87	4.23	67%	75.0	No	Moderate obstructive, mild restrictive defects. FVC and MVV invalid per Dr. Castle, DX 1-311. Mild obstruction. FVC and FEV_1 valid, MVV invalid per Dr. Long, DX 1-312.
DX 1 10/12/92 Vuskovich	52 73.22”	3.53	5.30	66%		No	No impairment

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 12/15/92 Wicker	52 74	3.72	5.56	66%	105	No	
DX 1-201 10/07/93 Dahhan	52 73.75"	2.64	4.33	78%	47.7	No	Invalid spirometry, normal lung volumes.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. Arterial blood gas studies submitted by the parties in connection with the current claim were in accordance with the limitations contained in 20 CFR § 725.414 (2006). Treatment records and records from the prior claim are not subject to the limitations. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 9	06/21/03	Baker	41	75	No	Mild resting arterial hypoxemia.
EX 2	12/08/03	Rosenberg	41	79.7	No	Decreased PO_2. Increased carboxyhemoglobin level consistent with cigarette smoking.

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
EX 1	09/16/04	Dahhan	45.2 45	74.5 83.7	No	Minimum hypoxemia at rest. Normal with exercise. Carboxyhemoglobin level was 2.7% indicating an individual smoking ½ pack of cigarettes per day.

The following chart summarizes the arterial blood gas studies available in connection with the prior claims.

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	06/18/92	Anderson	40.6	82	No	
DX 1	10/12/92	Vuskovich	40.2	81.4	No	Within normal limits.
DX 1	12/15/92	Wicker	39.5 39.5	76.5 86.1	No No	
DX 1	10/07/93	Dahhan	38.2 36.3	75.0 99.6	No No	Normal. Normal.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the

following treatment records and medical opinions submitted in connection with the current claim.

The Employer submitted treatment records from the U.K. Family Practice Center from 2003-2005, and the Appalachian Heart Center from 2004 and 2005. The Heart Center treatment notes (EX 4, 15, 16, and 17) reflect that the Claimant was seen there twice a year for ongoing medical management of chronic stable angina, single vessel coronary artery disease, and hypertension. The Claimant was advised to quit smoking. The Claimant has seen several doctors at the Family Practice Center in addition to Dr. Stepp.

Notes from a visit to the U.K. Family Practice Clinic on March 10, 2003, list chronic obstructive pulmonary disease (COPD) as the Claimant's first problem, and indicate that after a lengthy discussion about the need for the Claimant to stop smoking, he had cut back from two packs per day to 1/3 pack per day, and he intended to quit completely. EX 5. The Claimant returned for follow-up on April 24, 2003, complaining of problems with allergies. EX 6.

Dr. Glenn Baker examined the Claimant on behalf of the Department of Labor on June 21, 2003. DX 9. According to the American Board of Medical Specialties, Dr. Baker is Board-certified in Internal Medicine and Pulmonary Disease. He is also a B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, electrocardiogram, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 31 years. He reported a smoking history of one pack per day from age 16-18, and currently, 1/2 pack per day. The chest examination revealed bilateral expiratory wheezing upon auscultation. Dr. Baker read the x-ray as showing pneumoconiosis, 1/0. The pulmonary function test showed a moderate severe to severe obstructive impairment. The arterial blood gas study revealed mild resting arterial hypoxemia. No exercise study was administered due to the Claimant's ischemic heart disease. Dr. Baker diagnosed coal workers' pneumoconiosis 1/0, due to coal dust exposure, based upon the chest x-ray and coal dust exposure; COPD with moderate severe to severe obstructive defect, due to coal dust exposure and cigarette smoking, based on the pulmonary function tests; chronic bronchitis, due to coal dust exposure and cigarette smoking, based upon a history of cough, sputum production, and wheezing; hypoxemia, due to coal dust exposure and cigarette smoking, based on the pO_2; and, ischemic heart disease, due to atherosclerotic heart disease, based on a positive catheterization. Dr. Baker found that the Claimant had moderate to severe impairment in function based on his lungs, and that he does not retain the respiratory capacity to perform his last job in the mines.

In a supplemental report dated April 5, 2004, Dr. Baker elaborated on his opinion on the etiology of the Claimant's lung condition. DX 27. He stated that it was difficult to specifically determine whether cigarette smoking or coal mine dust exposure caused the Claimant's COPD. He cited a NIOSH study showing that nonsmoking miners and smoking nonminers have about the same reduction in FEV_1 over time. He also noted that other studies suggest that people who smoke who are also exposed to dust or other pulmonary irritants have more damage than those who only smoke. Overall, Dr. Baker opined that cigarette smoking and coal dust exposure contributed equally to the Claimant's COPD.

The Claimant returned to the Family Practice Clinic in July 2003 and reported that his allergies and shortness of breath on exertion had improved since his medications had been changed. EX 7.

Dr. Rosenberg examined the Claimant on behalf of the Employer on December 8, 2003. EX 2. Dr. Rosenberg also reviewed the Claimant's medical records from both claims, including Dr. Baker's report. Dr. Rosenberg is Board-certified in Internal Medicine and Pulmonary Disease, and a B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, electrocardiogram, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 31 years. He reported a smoking history of two packs per day from age 12 until four to five years before the examination, when he was smoking only 1/2 pack per day. The chest examination revealed markedly diminished breath sounds, with scattered rhonchi, without rales. Dr. Rosenberg read the x-ray as showing emphysema and some bullae formation, but no micronodularity.[6] The pulmonary function test revealed severe airflow obstruction, responsive to bronchodilators, with a significantly reduced diffusing capacity and no restriction. The resting arterial blood gas study was normal. An exercise study was not performed due to ongoing angina and borderline compensated cardiac status. Based upon his examination, Dr. Rosenberg concluded that the Claimant was not suffering from the interstitial form of coal workers' pneumoconiosis. In his opinion, the Claimant was suffering with a disabling airflow obstruction. Dr. Rosenberg opined that the Claimant's COPD was not caused by coal dust exposure since there was no evidence of micronodules associated with focal emphysema. He said the Claimant's severe disabling COPD, without evidence of micronodularity or complicated pneumoconiosis, was not caused or hastened by the past inhalation of coal mine dust. He also said that the impairment associated with coal dust exposure would be fixed, rather than responsive to bronchodilators. He said that the Claimant's COPD related to his long and continued smoking history.

The Claimant returned to the Family Practice Clinic on December 22, 2003, when he was assessed with an exacerbation of his COPD. His medications were again reviewed and prescribed. EX 8.

When the Claimant returned for follow-up on February 19, 2004, he reported that he was feeling very good. His shortness of breath was at baseline but slightly more on exertion since he had been smoking 1/2 pack per day. He indicated that he wanted to quit smoking. EX 9.

The Claimant returned to the Family Practice Center again on August 17, 2004. He complained of increasing shortness of breath, stating he had been getting progressively worse over the past year, with the last few months being especially bad. He attributed his worsening symptoms to his allergies. Physical examination revealed reduced breath sounds bilaterally. The assessment was worsening COPD. EX 10.

Dr. Dahhan examined the Claimant on behalf of the Employer on September 16, 2004. EX 1. Dr. Dahhan is Board-certified in Internal Medicine and Pulmonary Disease, and a

[6] It appears that Dr. Rosenberg relied on his own reading of the x-ray. The Employer did designate his x-ray reading as one on which it relied; rather, it designated a reading by Dr. Halbert. Dr. Rosenberg's reading of the x-ray is, therefore, not admissible. As he reviewed multiple x-ray readings from both claims, most of which were negative, however, the fact that one of the readings he relied on was inadmissible does not require that his opinion be discounted for that reason alone.

B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, electrocardiogram, chest x-ray, blood gas studies and pulmonary function testing. He also reviewed the Claimant's medical records from both claims, including the reports by Dr. Baker and Dr. Rosenberg. He reported that the Claimant worked in the mines for 31 years. He reported a smoking history of one pack per day from age 16 until two years before the examination (when the Claimant would have been 61 years old); thereafter, the Claimant reduced to 1/2 pack per day. The chest examination revealed increased AP diameter with hyperresonance to percussion. Auscultation revealed reduced air entry to both lungs with bilateral expiratory wheeze. The electrocardiogram was normal. Dr. Dahhan read the x-ray as showing clear lungs with no pleural or parenchymal abnormalities consistent with pneumoconiosis; he classified it as 0/0.[7] The pulmonary function test showed a severe obstructive ventilatory defect with partial response to bronchodilator therapy. Lung volume measurements showed hyperinflated lungs. The arterial blood gas study was normal. Dr. Dahhan observed that the Claimant's respiratory capacity had deteriorated significantly since Dr. Wicker's examination in December 1992, described on the table below. Based upon his examination, Dr. Dahhan concluded that there were insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on obstructive abnormalities on clinical examination and pulmonary function studies, adequate blood gas exchange, and negative x-ray reading. Dr. Dahhan found that the Claimant's ventilatory impairment was due to cigarette smoking, and that he did not retain the respiratory capacity to perform his last job in the mines. He based his opinion on the normal pulmonary function studies after he left the mines, saying that a disabling obstructive impairment secondary to coal dust exposure is rare. Additionally, Dr. Dahhan observed an improvement in the pulmonary function after administering bronchodilators, and the absence of evidence of complicated coal workers' pneumoconiosis.

In a deposition taken on March 24, 2006, Dr. Dahhan testified regarding his examination of the Claimant. EX 20. Dr. Dahhan reiterated the opinion he gave at the time of the examination. He said that both the 40-pack year history of cigarette smoking reported to him by the Claimant, or the 70-pack year smoking history appearing in other records, would be sufficient to cause the lung condition he observed in the Claimant. He agreed that 31 years of exposure to coal dust would be sufficient exposure for a susceptible individual to develop pneumoconiosis. He said that the Claimant did not suffer from clinical pneumoconiosis because the chest x-ray was negative, and the Claimant does not have a restrictive pulmonary impairment. He said the Claimant does not have legal pneumoconiosis, because coal dust would account for only a trivial amount of the loss in his FEV_1. He disagreed with Dr. Baker's conclusion that the amount of FEV_1 loss would be similar for both smokers and for coal miners who are not smokers. He also stated that coal dust-induced lung disease is usually fixed, and does not respond to the administration of bronchodilators. Finally, he said, there was no evidence of complicated coal workers' pneumoconiosis that may cause secondary obstructive abnormalities. He again concluded that the Claimant suffers from COPD caused by cigarette smoking, not coal dust exposure.

[7] It appears that Dr. Dahhan relied on his own reading of the x-ray. The Employer did designate his x-ray reading as one on which it relied; rather, it designated a reading by Dr. Wheeler. Dr. Dahhan's reading of the x-ray is, therefore, not admissible. Dr. Dahhan also saw an inadmissible reading of the June 21, 2003, x-ray, by Dr. Scatarige. As he reviewed multiple x-ray readings from both claims, most of which were negative, however, the fact that two of the readings he relied on were inadmissible does not require that his opinion be discounted for that reason alone.

When the Claimant returned to the Family Practice Clinic on March 8, 2005, he said he was feeling well and trying to get out more. He was still smoking 1/2 pack per day. The assessment said that his COPD symptoms were stable but he was wheezing. EX 11.

The Claimant was seen again on April 5, 2005, when he complained of cough and sinus congestion. The assessment included acute sinusitis, and a recommendation of increased nebulizer treatments for his cough. EX 12.

When the Claimant returned to the Family Practice Clinic on May 2, 2005, he reported recent chest pain for which he had been treated at the Heart Center. His cough was better. The assessment indicated that he did not have an exacerbation of his COPD, and that he had reduced his smoking, but needed to stop. The supervising physician noted that the Claimant had end stage COPD with a persistent cough for two months, and agreed with the recommended course of treatment. EX 14.

The following chart summarizes the medical opinions available in connection with the prior claims.

Date of Treatment, Examination, or Review of Records	**Ex. No. Physician Basis for Opinion**	**Opinion Regarding Existence of Pneumoconiosis**	**Opinion Regarding Lung Impairment or Disability**
06/18/92	DX 1-370 Anderson Examination	Pneumoconiosis based upon the chest x-ray.	Minimal decrease in pulmonary function. The Claimant retains the capacity to perform his coal mine work or a job or similar physical demand.
06/29/92	DX 1-364 Myers Examination	Pneumoconiosis based upon chest x-ray. COPD.	The Claimant retains the capacity to perform his coal mine work or a job or similar physical demand.
07/13/92	DX 1-278 Gilbert Treating Physician	Atypical chest pain.	
10/12/92	DX 1-299 Vuskovich Examination	Chronic bronchitis secondary to cigarette abuse. No occupational lung disease.	No impairment.
12/15/92	DX 1-360 Wicker Examination	Pneumoconiosis based upon chest x-ray.	Respiratory capacity appears adequate to perform his previous occupation in the coal mining industry.

Date of Treatment, Examination, or Review of Records	Ex. No. Physician Basis for Opinion	Opinion Regarding Existence of Pneumoconiosis	Opinion Regarding Lung Impairment or Disability
10/07/93	DX 1-193 Dahhan Examination	Insufficient objective evidence to diagnose pneumoconiosis. Chronic bronchitis due to cigarette smoking.	No impairment.
03/08/94	DX 1-114 Gilbert Treating Physician	Bronchitis, COPD, tobacco abuse.	

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies, and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

All three pulmonary function studies submitted in the current claim resulted in values qualifying for disability. Thus, these tests support a finding of total disability.

None of the arterial blood gas studies submitted in the current claim resulted in values qualifying for disability. Thus, these studies do not support a finding of total disability. I note, however, that the results of the arterial blood gas studies do not conflict with the results of the pulmonary function tests, because they measure different aspects of lung function.

As to the medical opinions in the current claim, the Claimant's treating physicians did not comment on whether the Claimant is disabled. However, all of the physicians consulted in

connection with the black lung claim agree that the Claimant's severe obstructive disease is disabling, and would prevent him from performing his coal mine work, or similar work in a dust-free environment. All of their opinions were based on the results of physical examinations and pulmonary function testing and, therefore, are documented and reasoned opinions.

Based on the results of the pulmonary function tests and the medical opinions admitted into evidence in the current claim, I find that the Claimant has established that he now suffers from a totally disabling pulmonary impairment. For this reason, he has also established that there has been a change in one of the applicable conditions of entitlement to benefits since his previous claim was denied. Considering the essentially normal results of the valid pulmonary function tests, and unanimity of the medical opinions obtained in the prior claim that the Claimant was not disabled, the evidence is compelling that the Claimant's pulmonary functioning has significantly declined between the time his initial claim was denied and the time he filed his current claim.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Claimant's medical records indicate that he has been diagnosed with coal workers' pneumoconiosis, as well as chronic obstructive pulmonary disease and chronic bronchitis, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("The Department reiterates … that the revised definition does not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

As I have found that the Claimant has established that there has been a change in conditions, I must consider all of the admissible evidence from both claims in reaching my determination whether the Claimant has established that he has pneumoconiosis. 20 CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at § 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

One x-ray in the current claim, and three in the prior claim, were read as both positive and negative by different readers. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are Board-certified Radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified Radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A Judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The record contains four readings of three x-rays taken during medical treatment which make no mention of pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). The earliest x-ray, taken in July 1992, was read by Dr. Gilbert to show no active cardiopulmonary pathology. I find this x-ray to be negative. The x-ray taken in March 1994 was read by a Radiologist, Dr. Patel, to show no active disease, but by Dr. Gilbert, to show emphysematous changes. I do not find this x-ray to be negative. Finally, an x-ray taken in April 2005 was read by the Radiologist, Dr. Ayos, to show COPD and slightly increased interstitial markings. I do not find this x-ray to be negative, either.

As to x-rays read in connection with the black lung claims, the earliest, taken June 18, 1992, was read as positive by Dr. Anderson, who had no particular qualifications for reading x-rays, and negative by Drs. Wiot and Spitz, both dually qualified readers, as well as by Dr. Fino, a B reader. I find this x-ray to be negative based on the greater qualifications of the doctors who found it to be negative.

The x-ray taken on June 29, 1992, was found to be positive by Dr. Myers, an A reader, and Dr. Aycoth, a B reader. The same x-ray was found to be negative by three dually qualified readers, Drs. Wiot, Spitz, and Pendergrass, and by a B reader, Dr. Fino. I also find this x-ray to be negative based on the greater qualifications of the doctors who found it to be negative.

The July 13, 1992, x-ray was found to be negative by three dually qualified readers. There are no positive readings. I find this x-ray to be negative.

The October 12, 1992, x-ray was read as negative by two B readers and two dually qualified readers. There are no positive readings. I find this x-ray to be negative as well.

The x-ray taken on December 15, 1992, was read as positive by Dr. Wicker, an A reader, and as negative by four dually qualified readers. I also find this x-ray to be negative based the greater qualifications of the doctors who found it to be negative.

The x-rays taken in October 1993 and March 1994 were also found to be negative by both B readers and dually qualified readers. There are no positive readings of either of these x-rays. I find them to be negative as well.

In the current claim, only the earliest, taken in June 2003, has been read as positive by Dr. Baker, who is a B reader. It was read as negative by Dr. Scott, who is dually qualified. I find this x-ray to be negative based on Dr. Scott's greater qualifications.

The two more recent films, taken in December 2003 and September 2004, have both been read only as negative, by dually qualified readers. There being no positive readings, I find these two x-rays to be negative.

As I have found all of the x-rays from both claims to be negative for pneumoconiosis (except for treatment x-rays, which are neither negative or positive), I cannot find that the Claimant has established that he has pneumoconiosis based on the x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields, above*. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (*en banc*).

The Department of Labor has taken the position that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. This underlying premise was stated explicitly in the commentary that accompanied the final version of the current regulations. The Department concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. **The risk is additive with cigarette smoking**." 65 Fed. Reg. at 79940 (emphasis added). Citing to studies and medical literature reviews conducted by NIOSH, the Department quoted the following from NIOSH:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. **Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present**.…

65 Fed. Reg. at 79943 (emphasis added). Moreover, the Department concluded that the medical literature "support[s] the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms." Medical opinions which are based on the premise that coal dust-related obstructive disease is completely distinct from smoking-related disease, or that it is not clinically significant, are, therefore, contrary to the premises underlying the regulations. I have considered how to weigh the conflicting medical opinions in this case based on these principles.

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). In this case, the Claimant identified Dr. Stepp as his current treating physician. Dr. Stepp practices at the U.K. Family Practice Clinic, where the Claimant is being treated for COPD. Although treatment records from both the Family Practice Center and the Appalachian Heart Center reflect that the Claimant has been advised to stop smoking, none of the records from either treating facility address the etiology of the Claimant's lung disease.

Of the physicians who examined the Claimant or reviewed his records in connection with his current black lung claim, Drs. Rosenberg and Dahhan said that the Claimant does not have pneumoconiosis, while Dr. Baker said that he does. Dr. Baker read the x-ray taken as part of his examination to be positive. He also said that coal dust and cigarette smoking contributed to the Claimant's obstructive disease. I construe Dr. Baker's opinion to be a diagnosis of both clinical and legal pneumoconiosis. All of the physicians who provided medical opinions did so based on adequate underlying documentation. All provided at least some rationale in support of their conclusions. Thus, I consider all of these medical opinions to represent documented and reasoned medical opinions.

Dr. Baker's diagnosis of clinical pneumoconiosis is weakened by his reliance on his positive x-ray interpretation. That film was reread as negative by a dually qualified reader, and I have found that it constitutes a negative x-ray. His diagnosis of legal pneumoconiosis, however, is based on his view that the roles of coal dust and cigarette smoking in the development of COPD in miners cannot be specifically determined. His view is consistent with the underlying premises of the regulations, and I give it probative weight. Although Dr. Baker found a less extensive smoking history than I have found, his reasoning still applies that both smoking and coal dust exposure contributed to the Claimant's disabling COPD.

Both Dr. Rosenberg and Dr. Dahhan, on the other hand, attribute the Claimant's COPD entirely to smoking. Dr. Rosenberg based his opinion on the absence of micronodularity or complicated pneumoconiosis. His comments indicate that he was focused on the presence of clinical pneumoconiosis. He also relied on the fact that the Claimant's obstructive impairment was partially reversible with bronchodilators, but offered no explanation for the irreversible obstruction remaining. Dr. Dahhan, on the other hand, appeared to address both clinical and legal pneumoconiosis. His opinion that coal dust would contribute only a "trivial" amount to the loss of FEV_1 in a miner who also smokes, is contrary to the premises underlying the regulations. Neither Dr. Rosenberg nor Dr. Dahhan offered any convincing explanation why they attributed

the Claimant's COPD entirely, or almost entirely, to cigarette smoke. Hence, I give their opinions little weight on the issue of legal pneumoconiosis.

After weighing all of the medical opinions in the current claim, I resolve the conflict by according greater probative weight to the opinion of Drs. Rosenberg and Dahhan on the issue of clinical pneumoconiosis, but greater probative weight to the opinion of Dr. Baker on the issue of legal pneumoconiosis. All three doctors possess excellent credentials in the field of pulmonary disease. All three had the opportunity to examine the Claimant, and obtain objective evidence. I find the opinions of Drs. Rosenberg and Dahhan to be better supported by the objective evidence that the Claimant does not have clinical pneumoconiosis, as the x-ray evidence is negative. However, I find that Dr. Baker's reasoning and explanation in support of his conclusion that the Claimant has legal pneumoconiosis is consistent with the premises underlying the regulations, and in better accord both with the evidence underlying his opinion and the overall weight of the medical evidence of record. Thus, I find, based on the recent medical opinion evidence, that the Claimant has established that he has legal, but not clinical, pneumoconiosis.

The medical opinions found in the previous claim given between 1992 and 1994. The Claimant's then treating physician, Dr. Gilbert, did not address the etiology of his COPD. None of the physicians who gave opinions on the presence or absence of pneumoconiosis addressed the distinction between clinical and legal pneumoconiosis. The doctors who diagnosed pneumoconiosis did so based on positive readings of x-rays which I have found to be negative for pneumoconiosis. The doctors who were of the opinion that the Claimant had COPD due to smoking alone offered no explanation for excluding coal dust exposure as a contributing factor. Thus, I find that the medical opinion evidence from the prior claim is entitled to little weight, and does not undermine my finding that the Claimant has established the presence of legal pneumoconiosis based on the opinion of Dr. Baker.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for at least 28 years and, therefore, is entitled to the presumption. The Employer has not offered evidence sufficient to rebut the presumption. The 10th Circuit Court of Appeals has held that the presumption applies only when the miner has established that he has clinical pneumoconiosis. *Anderson v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006). In this case, I have found that the Claimant has established that he has legal, but not clinical, pneumoconiosis. I also find that he has established a causal relationship between his disease and his coal mine employment through the opinion of Dr. Baker.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2006); *Tennessee Consol. Coal Co. v. Kirk*, 264 F.3d 602, 610 (6th Cir. 2001).

The current regulations state that unless otherwise provided, the burden of proving a fact rests with the party making the allegation. 20 CFR § 725.103 (2006). The Benefits Review Board has held that § 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. *See* 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). I find that the Claimant has established that pneumoconiosis is a substantially contributing cause of his disability through the opinion of Dr. Baker.

In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly in point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116. *See also Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002). I can find no specific and persuasive reasons for concluding that the opinions of Drs. Rosenberg and Dahhan that exposure to coal dust did not cause or contribute to the Claimant's disability did not rest upon their disagreement with my finding that the Claimant has legal pneumoconiosis. Accordingly, I give little weight to their opinions on this issue.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2006); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

The Claimant filed his claim for benefits in June 2003. When he was examined by Dr. Baker later that same month, he was already totally disabled. The regulation regarding

subsequent claims also provides, however, that "In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final." 20 CFR § 725.309(d)(5). The ALJ issued his decision and order on the Claimant's prior claim on August 29, 1995. As the Claimant took no further action on that claim, it became final one year later, on August 29, 1996. The record does not establish when he first became disabled, however, as Dr. Baker's examination in June 2003 is the first available evidence of the Claimant's pulmonary impairment which had developed some time after his previous claim was denied.

I find that the Claimant is entitled to benefits commencing in June 2003, the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established that he has pneumoconiosis arising out of his coal mine employment, and a totally disabling pulmonary or respiratory impairment caused by pneumoconiosis. Thus, the Claimant has met his burden of showing a change in an applicable condition of entitlement pursuant to § 725.309(d). Accordingly, the Claimant is entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, .365, and .366 (2006). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on June 4, 2003, is hereby GRANTED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's Decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and

the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).